Gender and Tobacco Addiction in Mizoram

H.ELIZABETH, Assistant Professor

Department of Social Work, School of Social Sciences

Mizoram University

ABSTRACT

Despite the fact that tobacco consumption is one of the largest preventable deaths in the world the trend is increasing day by day. It is alarming everywhere regardless of the societal backgrounds and or socio-economic profile of the users. Many cultures do not sanction and disapprove the use of tobacco by women in any forms. However, many women worldwide are using tobacco in any of the forms and even addicted to it which is mainly due to the developing neurobiological dependency over nicotine. The prevalence of tobacco use among all the states and Union Territories in India ranges from the highest of 67 percent in Mizoram to the lowest of 9 percent in Goa (GATS 2009 -2010). Tobacco use is much higher among both males and females in scheduled tribes (ST) compared to other caste groups and exceed the national average. The reported high prevalence of tobacco in the North-Eastern part of India is consistent with the findings of the Global School Personnel Survey (GSPS, 2001) and the National Household Survey of Drugs and Alcohol Abuse, 2002. Therefore it is significant to know how and why Mizo women tobacco users are developing dependency and addicted to nicotine.

The study on *gender and tobacco addiction in Mizoram* was conducted in the year 2012 among 350 Mizo women tobacco users in Aizawl district, Mizoram. The respondents are in the reproductive age group between 13 years – 45 years. The study had qualitative and quantitative approaches and data was collected through semi structured interview schedule.

The present paper tries to explore and examine the *tobacco addiction* by Mizo women that is measures based on *psychological dependency and physical dependency* and the *physical addiction and psychological addiction and its relationship between the physical state and psychological state* to tobacco addiction.

The finding of the study has shown that the use of tobacco by the respondents (tribal Mizo women) is closely related to physical and psychological addition. In other words, the use of tobacco by the tribal Mizo women is at the psychological level and is due to the physical dependency.

Keywords: Addiction, Dependency, Nicotine.

Introduction

Tobacco consumption is becoming a public health concern today. The World Health Organization (WHO), 2005 has reported that tobacco use is responsible for about 5 million deaths per year worldwide. Furthermore, half of the people who smoke today will die prematurely. Smoking is the single most preventable cause of illness and death in our society and is responsible for almost half a million deaths due to cancer, heart disease, stroke, complications of pregnancy, and respiratory illness (Centers for Disease Control and Prevention [CDC], 2002a, 2002b, 2005b; U.S. Department of Health and Human Services [USDHHS], 2004). It is simply because of the fact that abstaining from smoking is the single most important preventive health behavior. It is found that African-American women can engage into significantly reduce their chances of morbidity and premature mortality related to these illnesses (USDHHS, 2000).

Tobacco itself is a plant which contains many toxins and is harmful to humans. It is manufactured in various forms and it can be taken by anyone. However, tobacco once taken usually leads to dependency and addiction due to the nicotine and other chemicals present both in the raw and processed tobacco that affected human health. Hence, health as defined by WHO is well-being, sound body and sound mind, not the mere absence of disease or infirmity'. Therefore, positive health' includes all the physical, psychological, cultural, social, environment and political conditions.

The addictive subject in tobacco is Nicotine that cause changes to the brain and behavior. The broad leafed plant originated in America is one of the most widely abuse psychoactive or mind altering substance. When it enters the blood stream, either through the lungs, the skin inside the mouth, or the nasal passages and or it moves to the brain. In fact, nicotine causes two sensations - stimulation in the thought process, and general relaxation in the users. Also, it enhances memory and promotes a feeling of well being. In other words, it stimulates the brain's reward system and making the users feel good. Further, *nicotine dependency and or nicotine exposure* is similar in smokeless tobacco users and smokers and often leads to strong physical dependence. As a rule, smokeless tobacco products contain high levels of nitrosamines with carcinogenic potency in experimental animals. Therefore, tobacco dependence (TD) is a complex disorder resulting from the interplay of multiple factors beyond cigarette consumption. According to the nicotine sensitivity model, TD is strongly related to individual sensitivity to nicotine. However, current knowledge of risk factors for the onset and maintenance of TD as well as of indicators of increased susceptibility to the effects of tobacco and, in particular, nicotine is lacking, and the etiologic contribution of possible risk factors has not been accurately quantified. Hence, Markou and Henningfield (2003) noted that nicotine is a psychoactive drug that triggers the brain and throughout the body that can, in turn, act

in concert to reinforce tobacco use. While, only a short-term exposure to nicotine has been shown to induce long-lasting changes of the excitatory input into the brain's reward system, which may be an important early step in the path to addiction (Lavallette and van der Kooy 2004). So, Picciotto (2003) has marked that an individual differs greatly in his or her sensitivity to nicotine dependence; evidence suggests that most adults are susceptible to the biological effects of nicotine and tobacco.

It is relevant to understand nicotine dependence in tobacco addiction. Nicotine dependence has been established as the primary factor responsible for the maintenance of smoking, and dependence severity strongly predicts withdrawal severity and relapse. The recent conceptualizations have emphasized the multidimensional nature of dependence, which encompasses factors such as negative (e.g., smoking to alleviate negative affect) and positive (e.g., smoking to enhance mood) reinforcement, and automaticity (e.g., automatically reaching for a cigarette after quitting and disposing of cigarettes). Degree of mindfulness and level of nicotine dependence are hypothesized to be related because mindfulness reduces both self-report and objective indices of negative affect and stress, and is associated with enhanced positive affect.

Among the several ways of nicotine consumption all over the world, it is observed that smoking is the most common and quick acting manner. The use of tobacco may be broadly classified into two forms such as 'smoke' and 'smokeless forms'. The 'smoked tobacco' (ST) means tobacco which is ingested by smoking like *cigarette, beedi, Cheroots* and others. In addition, the risks of tobacco use include the risks to others known as *passive smoking or secondhand smoke*. On the otherhand, 'smokeless tobacco' (SLT) is used to describe the tobacco that is consumed without heating or burning at the time of use. The oral use of smokeless tobacco is widely prevalent in India with different methods of consumption like chewing, sucking and applying tobacco preparation to the teeth and gums.

The present paper on gender and tobacco addiction in Mizoram tries to probe *'addiction'* which is deeper than dependency and it is the situation where a person cannot live or stay without it and also the body is ruined by it. The word 'addiction' has been used to describe two very different phenomena, with very different clinical significance and applicability. However, the extent of this dichotomy between psychological and neurobiological views has received attention. Partly this is because for some there is no dichotomy – the mind is seen as simply the result of functions of the brain, as expressed in the maxim: 'the mind is what the brain does' (Waldrop, 1992). It is worthy to note that tobacco addiction is also like a disease which often may appear after many years of abstinence.

The assessment for tobacco dependence is based on the six criteria given in the International Classification of Diseases, 10th revision known as ICD 10 which includes a strong desire or sense of compulsion to take tobacco, difficulties in controlling tobacco taking behavior in terms of its onset, termination, or levels of use, a physiological withdrawal state when tobacco use has ceased or been reduced, the characteristic withdrawal syndrome for tobacco, or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms, evidence of tolerance, such that increased doses of tobacco are required in order to achieve effects originally produced by lower doses; progressive neglect of alternative pleasure or interests because of tobacco use, increased amount of time necessary to obtain or take the substance or to recover from its effects, progressive neglect of alternative pleasure or interests because of tobacco use, increased amount of time necessary to obtain or take the substance or to recover from its effects and persisting with tobacco use despite clear evidence of overtly harmful consequences, such as depressive mood states consequent to periods of heavy substance use, or drug related impairment of cognitive functioning.

Concern on Gender and Tobacco Use

Tobacco use by women is strictly forbidden in many cultures while it is openly permitted in some communities. The study shows that the Mizo women use tobacco largely regardless of their age or geographical residence. The tradition and practice of using tobacco by the Mizo women did not have restrictions or societal disapproval. Historically, it has rooted traditionally and became a part of their lifestyle mainly started with an engagement in the agricultural field. Here, the backbone of the Mizo economy which is cultivation has contributed a lot that, the girl child started working in field and insects disturbed them in the midst of the work. So, to prevent them from mosquito bites that may cause fever and infections, the elders used to pluck tobacco leaf from nearby the sites. It was rolled immediately and offered to them as a mosquito repellent. In addition, in those days, tobacco leaves were carried from the fields and kept it ready at home as a first aid disinfectant. All the members of the family excluding children smoked openly and the use of tobacco by children within the house depended upon their choice. Using of tobacco by minors at home was not a common practice among the Mizo families. Therefore, the use of smoke and smokeless forms of tobacco already existed and was mainly confined to three types of tobacco products like smoking of local bidi i.e nicotine roll *(vaihlo zial /zozial*), smoking of water pipe tobacco *(vaibel)* and taking of tobacco instilled water *(tuibur).* The pregnant women usually ate the ashes of rolled local bidi which was taken mainly due to having salty taste. The harmful effect of taking tobacco during pregnancy and harm to the reproductive health was not well known apparently in the past. The main reason for

taking tobacco during pregnancy was largely to avoid nausea and feeling of discomfort during the early trimester of pregnancy

Many of the studies have reflected that an approximate of one third of female smokers quit once they learn that they are pregnant (Fingerhut, Kleinman, & Kendrick, 1990 ; Floyd, Rimer, Giovino, Mullen, & Sullivan, 1993 ; LeClere & Wilson, 1997 ; Severson, Andrews, Lichtenstein, Wall, & Zoref, 1995), but up to two-thirds of women who stop smoking during pregnancy relapses within 6 months after delivery (Colman & Joyce, 2003 ; Fingerhut et al., 1990 ; Martin et al., 2008 ; McBride & Pirie, 1990 ; McBride, Pirie, & Curry, 1992 ; Ratner, Johnson, Bottorff, Dahinten, & Hall, 2000). Women who remain tobacco abstinent after delivery experience health benefits that include protection of infants from secondhand smoke exposure, lower risk of poor pregnancy outcomes in subsequent pregnancies, and decreased personal risk of tobacco-related health problems (Mullen, 2004). To increase the proportion of women who maintain tobacco abstinence after delivery, it is necessary to understand the modifiable factors associated with postpartum relapse to smoking.

Women in general tend to perceive water pipe use more positively than cigarette smoking, with women water pipe users noting its positive attributes of being familiar, looking traditional, and being social (Maziak, Ward, Soweid, et al., 2004). Other studies in the Middle East indicate that women find water pipe smoking to be attractive (Maziak, Rastam et al., 2004) and an occasion when they can participate with others (Tamim, Terro et al., 2003).The water pipe, also known as *shisha, hookah, narghile, goza*, and *hubble bubble*, has long been used for tobacco consumption in the Middle East, India, and parts of Asia, and more recently has been introduced into the smokeless tobacco market in western nations.

In the general population, depression, anxiety, and stress are more common among smokers than nonsmokers; these factors are barriers to smoking cessation and triggers for relapse (Breslau, Kilbey, & Andreski, 1991; Curry & McBride, 1994; Glassman & Covey, 1996; Glassman et al., 1990; Hall, Munoz, Reus, & Sees, 1993 ; Kendler et al., 1993). Among pregnant women, current and former smokers are more likely to report depressive symptoms than never-smokers (Zhu &Valbo, 2002), and pregnant smokers are more likely than pregnant nonsmokers to have a mood disorder (major depressive disorder, dysthymia, and hypomania) or an anxiety disorder (panic disorder, phobia, and generalized anxiety disorder; Goodwin, Keyes, & Simuro, 2007). Although pregnant women who quit during pregnancy have lower levels of depressive and stress symptoms, compared with women who continue to smoke (Blalock, Robinson, Wetter, & Cinciripini, 2006 ; Bullock, Mears, Woodcock, & Record, 2001 ; Ludman et al., 2000), prenatal quitters are at risk for both mood fluctuations and smoking relapse after delivery.

The rise in tobacco use among younger females in high-population countries is one of the most ominous potential developments of the epidemic's growth. In many countries, women have traditionally not used tobacco: women smoke at about one fourth the rates of men. Most women currently do not use tobacco however, the tobacco industry tap this potential of new market mainly through media - advertising, promotion and sponsorship, including charitable donations to women's causes, weaken cultural opposition to women using tobacco (Gilmore A et al. American Journal of Public Health, 2004). Further, in most of the European Union countries, teenage girls are as likely to smoke as boys, if not more likely (Global youth tobacco survey, U.S. Centers for Disease Control and Prevention, 2007).

Johnson (2003) suggested dividing addiction into three types: psychological, Physical, and what he termed addictive character. Others have claimed that neurobiological factors alone explain all addiction, that addiction is a 'chronic relapsing disease of the brain'. Some have said that the very fact of vulnerability to relapse in addicts implies that addiction must be caused by long-lasting changes in brain function (Kalivas & Volkow, 2005). However, relapse to old symptomatology is also a well-known property of human psychology, due to the lasting nature of character and emotional conflict over a lifetime. Robins showed that Vietnam veterans were able to stop their extensive use of heroin upon return to the USA despite having become physically dependent and presumably having developed the brain changes known to occur with prolonged drug use. In contrast, heroin addicts from the same time who remained in the USA could not stop use after the same detoxification treatment. Otherwise, the veterans had the form of 'addiction' that is described by physical dependency: they had (only) a physical addiction (physical dependency) that was resolvable with detoxification. This is the same use of the term 'addiction' that describes many cigarette smokers and others whose use is not determined by psychological factors but rather by physiologically-induced cravings (due to withdrawal) and habit. In contrast, the addicts who stayed at home were using heroin as a psychological symptom as described above, a kind of addiction that cannot be resolved by detoxification.

The tobacco dependence is measures based on psychological dependency and psychological addiction, craving for tobacco, physical dependency and physical addiction.

Figures, Tables & Equations: There should be simple, centered, separately numbered & self-explained, and titles must be above the tables/figures. Sources of data should be mentioned below the table/figure. It should be ensured that tables/figures are referred to from the main text

Table 1: Tobacco Dependence

Sl.No	Tobacco Dependence	Locality					
		Rural n = 105		Urban n = 245		Total n =350	
		Mean	S.D	Mean	S.D	Mean	S.D
1	Tobacco leads to psychological dependency	2	0.9	3	1.1	2.5	1.1
2	Psychologically addicted to tobacco	2	1.0	3	1.1	2.4	1.1
3	Craving for tobacco	2	0.8	2	0.9	2.3	0.8
4	Tobacco leads to physical dependency	2	0.9	2	0.9	2.1	0.9
5	Physically addicted to tobacco	2	1.0	2	0.9	1.8	0.9
	Tobacco Dependence	2	0.8	2	0.8	2.2	0.8

Source: Computed

The dependency on tobacco is developing after prolonged use and when an individual cannot stay without using it. However the level and degree of dependence is varying and the self reported data has shown that the respondents are having physical dependency or psychological dependency and or both. The Table 1 on tobacco dependence shows that a mean value of 3 is label for the psychological dependency and psychological addiction while a mean value of 2 for physical craving, physical dependency and addiction among the respondents belonging to urban areas. On the other hand the same attempts have been made among the respondents from the rural communities and the mean value for physical and psychological craving, dependency and addiction is 2. This has shown that the use of tobacco by the respondents (tribal Mizo women) is closely related to physical and psychological addition. In other words, the use of tobacco by the tribal Mizo women is at the psychological level and is due to the physical dependency.

In the above findings, it is also significant to explore the *physically addiction to tobacco* and the *psychologically addiction to tobacco* as well. Addicted users of nicotine become tolerant to the drug; that is, despite experiencing initial unpleasant side effects such as tremulousness, dizziness, and nausea, such users increase their dosage until it levels off at one that fulfils their need. Therefore, the users seek nicotine continually. Some users of smokeless tobacco use it even while sleeping. The physical dependence associated with nicotine induces withdrawal symptoms when addicted users abruptly discontinue its use. So, the ex-users often experience craving for nicotine and many become users again.

Table 2: Relationship between Physical and Psychological

Addiction of Tobacco Use

Sl.No	Psychologically addicted to tobacco	Physically addicted to tobacco (%)				
		Never	Sometimes	Mostly	Always	Total
1	Never	65.4	5.2	0	0	70.6
2	Sometimes	8.8	44.8	9.1	4.0	66.7
3	Mostly	17.0	30.6	77.3	4.0	128.9
3	Always	8.8	19.4	13.6	92.0	133.8

Source: Computed Figures in parentheses are percentages

The table 2 on the Relationship between physical addiction and psychological addiction to tobacco use has shown that there is a positive relationship between physical and psychological dependency of tobacco use. Spearman correlation (.5%) is positive and significant at 1% level. It also shows that most of the respondents who are feeling always physically addicted to tobacco feels that they are always psychologically addicted to tobacco (92%). Majority of the respondents who feel physically addicted to tobacco also feel that they are psychologically addicted to tobacco (77%). Similarly, the respondents those who sometimes feel physically addicted to tobacco also sometimes feel that they are psychologically addicted to tobacco (45%). On the other hand, most of the respondents who are never physically addicted to tobacco are also never had a feeling of psychologically addiction to tobacco (65%). Hence, the physical addition goes along with the

psychological craving and addiction and also who had never experience a physically addiction to tobacco also never experience the psychological demands.

While probing dependency and or addiction, it is relevant to explore the frequency of tobacco use in a day by the respondents. The Table 3 on the Frequency of tobacco use by the respondents shows that 51.4% were *frequent users of tobacco* that *is using tobacco between 5 times and 8 times per day.*

Table 3: Frequency of Tobacco Use

Sl.No	Use	Frequency	Percent
1	Always	43	12.3
2	Frequently	180	51.4
3	Occasionally	57	16.3
4	Rarely	70	20.0
	Total	350	100

Source: Computed

This category of users are *dual users including smoke and smokeless forms* such as *sahdah, khaini*, tobacco instilled water, smoking, betel quit with tobacco, *zarda paan* and others. The respondent's regularly *using tobacco twice or trice times a week is called rare user*. Out of the total respondent, 20 % are the rare users who are using tobacco as compensation to being feeling occupied out of their boredom of loneliness and usually happen when mingled and socialization with tobacco users. Therefore, the peer pressure, seeking for conformity to groups, social approval, and tobacco as a mechanism of networking in social gatherings are also relevant. The other group of tobacco user having 16.3 % respondents is the *occasional user.* The respondents reveals that tobacco was used based on the availability in the nearby surroundings as well based on their getting of opportunity of using tobacco. However, the most dangerous and crucial group of tobacco user having 12.3% respondents has fall under the category of *always and continuous tobacco user (Regular users)*. The respondents use tobacco in any form and with any types beyond ten times a day. They reported that they continuously used unless they were in a formal functions, meetings or else during the sleep.

In conclusion, the background of the study shows that 39.4% of the respondents are young women in the age bracket of 19 -35 years from both rural and urban tribal communities. The distribution shows that 41.2% are belonging to urban communities and 35.2 % respondents from rural areas. The remaining 13.4 % were minors between the age of 13 -18 years and out of which 15.9% were from urban areas against 7.6% from rural areas. Also 47.1% of the respondents are women above 36 years. From the distribution of pattren of tobacco use, it is known that the use of smoke forms of tobacco by women is much higher in the rural areas (16.2%) as compared to 8.9% in the urban communities. While, the smoke forms of tobacco used by the respondents are *cigarrete*, *zozial*, Bidi and pipe tobacco. But, the other smoke forms of tobacco like *cigars, cheroots, dhumti*, pipe tobacco, *chilum, hookah* which are largely used in other parts of the country are not practice by the respondents of the study. *And the mean value for using smoke forms of tobacco is 10.4*. The use of smokeless tobacco is largely prevalent in both rural and urban communities and the practice is observed to be more among urban respondents as compared to rural respondents. Majority of the respondents 89.6% are using smokeless tobacco like paan (betel quit with tobacco), paan with zarda, *sahdah*, khaini, *tuibur* and other gutkha products. The other smokeless forms of tobacco like *mishri, snus*, Manipuri tobacco, *Mawa, gul, bajjar, gudhaku* are contemporary in other parts but not practiced.*The mean age of tobacco use by the respondents was 36.5 years.*

It is observed that the traditional beliefs and or the magical beliefs are still strong among the respondents. Majority of the respondents take tobacco products both in smoke forms and smokeless forms as a *mouth refreshment* .The mean for urban is 2.7 and 2.6 for rural respondents. The respondents usually has taken the tobacco products soon after meal, taking food especially those which are highly flavour like pork, oily and spicy foods, garlic, sweets and foods which are very sour and hot. Once it has been taken, the respondents assumed that the natural taste and the condition of the tongue have returned back to normal. So, it is use as mouth refreshment to regain the normal smell of the mouth. Secondly, it is also use as mouth cleaner to avoid the foul smell and odour caused by food. Some of the respondents reported that they had dental problems and the others did not brush their teeth regularly which also induce unhygienic smell. Therefore, to get out of those situations, the adult respondent usually has taken *tuibur, paan and paan with zarda* and smoke cigarettes or *zozial* and the minor respondents used *gutkha* products.

In connection to this, the respondents both from the rural and urban communities have highly used tobacco products as a coping mechanism for coping from stress. The respondents have come across many stressors, big and small which they cannot handle efficiently. In such case, the respondents started responding to the situation by taking tobacco. Here, taking of tobacco products

in a huge quantity or continuously taking it and function as a way of coping mechanism is assumed to be due to nicotine content in the tobacco products and is likely utilized as a stimulant.

Every culture is having its own practices and many of these clashes with the scientific knowledge. The tradition is passed on from generation to generation and some people are overwhelmed by modernization and advancement. The respondents use tobacco water to help get relief from toothache. The mean value of using tobacco water for this purpose is 2.5 among the rural respondents and 2.4 among the urban respondents. The respondents largely accepted that most of the toothache is general where they need not consult the dentist and taking of tobacco water is sufficient to relieve the conditions. In the case of children, the tobacco water is pasted on a piece of linen or cotton ball and put on aching teeth. It is also further important to note that tobacco water is also put on the skin rash due to insects' bites. The assumption is that the nicotine content of the tobacco water kills germs however; in case of toothache tobacco water relieves the pain but not cure.

The other psychological aspects of using tobacco products by the respondents are to *avoid nausea*. This reflects that tobacco use is related practiced during pregnancy and it is more or less similar among the urban and rural respondents and the mean value is 2.3 and 2.4 respectively. Without having insight of the harmful consequences on health of a pregnant mother and her fetus, tobacco is consumed by the respondents even during pregnancy. Further information in this area reflected that a pregnant mother is usually smoking and also ate the ashes of smokes.

Many of the respondents are using tobacco due to *being bored*, without having focus and constructive thoughts. It induces the temptation when they are alone and the mean value for using tobacco as *time pass* is 2.4 which is higher in urban communities as compared to rural areas which is 2.0. At the same time, use of tobacco in a group or while with friend is more likely to be popular among the rural respondents as compared to the urban respondents. Further, some of the respondents have reported that they sometimes feel bored using tobacco but in spite of the fact they are still using it which is related with the development of psychological dependency.

Apart from the above factors, the other common reason given by the respondents is that using of tobacco at late night helps them to remain awake and overcome the feeling of sleepiness. There are many personal factors involving which made the respondents not feeling sleepy at nights. Besides, the Mizo society has a practice of going and staying overnight to condolence the family on the first night when there is a death. The gatherers are not permitted to sleep or look sleepy. Therefore, to remain awake at late night the respondents take tobacco. Likewise, when there is a

patient in a critical condition, relatives, friends, neighbors and well wishers are gathered together nearby the patient and even stay overnight as necessary.

The findings from the study on gender and tobacco addiction in Mizoram has shown the prevalence and high rate of tobacco consumption by the Mizo tribal women in both smoke and smokeless form which is above the national average. The practice is very much common in all the age group and the variation of pattern of use is observed as well. The consumption of smokeless form of tobacco is greater among respondents belonging to urban communities as compared to that of the respondents belonging in rural communities. It is also because of the recent flow-in of attractive tobacco products that are available in small sachet at a cheap price which is affordable even for children without having income. In line with this the use of smoke form of tobacco is common in rural communities as compare to the respondents belonging to urban communities. It is important to consider that the easy accessibility of zozial (local cigarette) at low cost increase the rate of smoke tobacco in rural areas. Moreover, the differences in trends show that the respondents belonging in the urban communities prefer using smokeless tobacco mainly due to its smartness that could be done in secret or hidden places. And they are uncomfortable with smoking that could be observed by anyone. So, the few respondents who are smoking belonging to urban communities usually smokes alone, inside the bathroom, toilet and not in the public places. While, the respondents belonging to the rural communities mainly smoke zozial that is less expensive and easily available to access. Despite the social disapproval, women smoker usually have no sense of connection of dignity of women with smoking. Overall, tobacco products both in smoke form or smokeless form are easily accessible in the environment and the availability of less expensive tobacco products increase the rate of consumption of tobacco. In addition, the social networks is strong in this particular culture, therefore, as a hospitality tobacco is offer to the near person without considering the harmful consequences.

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